NFL Player Disability & Neurocognitive Benefit Plan

Total and Permanent Disability Benefits Application

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INSTRUCTIONS

Important Reminders

- **Read all explanations and instructions carefully.**

- **Fill out the Total and Permanent Disability Benefits Application ("Application") to apply for total and permanent disability ("T&P") benefits from the NFL Player Disability & Neurocognitive Benefit Plan ("Disability Plan").**

  If you have any questions about your Application, call the Plan Office at 800-638-3186.

- **Mail the completed Application and documentation to:**

  NFL PLAYER DISABILITY & NEUROCOGNITIVE BENEFIT PLAN
  200 SAINT PAUL ST STE 2420
  BALTIMORE MD 21202

To apply for T&P benefits from the Disability Plan, you must complete this Application and return it to the Plan Office with all required information. The Plan Office will tell you if further information is required. Your Application will not be complete until the Plan Office receives this Application with all required information, and receives all documents and additional information that you intend to include.

The Disability Plan does not provide T&P benefits for periods more than 2 months before your Application is received by the Plan Office, unless you are found to have been mentally or physically incapacitated in a manner that substantially interfered with the filing of this Application. If an exception is granted, you may receive up to 36 months of retroactive T&P benefits. If you seek an exception to the 2-month rule, please explain on an additional sheet.

Signature and Authorization

Your signature certifies that the information provided is accurate and complete, and authorizes the consideration and use of your medical information to evaluate your Application. In connection with your Application, you may submit, or have submitted on your behalf, individually identifiable health information, including your Application, medical records, and physician reports. You also may be referred to Plan-neutral physicians or Medical Advisory Physicians for medical examinations, and these physicians may submit health information to the Disability Plan on your behalf.

You may be subject to loss of benefits and to other penalties and sanctions under law if you have made any false or misleading statements or omissions.

Medical, Hospital and Other Records

You are encouraged to provide any information you believe will be helpful to the consideration of your Application. You may wish to enclose copies of your medical, hospital or other records. You may get a copy of medical or hospital records by asking your providers (that is, physicians, hospitals, etc. that have treated you) for your records. Medical, hospital, and other records must be received by the Plan Office no less than 10 days before the date of your neutral physician exam. Such materials received within 10 days will not be considered by the neutral physician.

Disabilities and Cause

If you are totally and permanently disabled, as defined below, you may be able to receive a T&P benefit if:

- You are an Active Player or a Vested Inactive Player;
- You have at least one Credited Season after 1958; and
- You are not vested based solely on special rules in the Retirement Plan.

In general, you are totally and permanently disabled if the Disability Initial Claims Committee or the Disability Board determines that you are substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit. You will not be considered to be able to engage in any occupation or employment for remuneration or profit merely because you are employed by the NFL or an NFL club, manage personal or family investments, are employed by or associated with a charitable organization, or are employed out of benevolence. You are not totally and permanently disabled under the Disability Plan as a result of a disability suffered while in the military service of any country.

In general, Players who apply for T&P benefits are referred to a neutral physician and/or to an institution selected by the Disability Board for a medical examination. You must submit to any required medical examination to be eligible for T&P benefits. If you do not appear at any medical examination, your Application will be denied, unless you provide at least 2 business days advance notice of your inability to attend. This rule may be waived if circumstances beyond your control preclude your attendance without advance notice.

Social Security

You will be considered totally and permanently disabled if you otherwise meet the criteria for this benefit and have been awarded disability benefits under the Social Security disability insurance or Supplemental Security Income programs because you are unable to work, unless the Disability Board determines that you are receiving such benefits fraudulently. To qualify, you must submit evidence that you are receiving these benefits at the time of your Application. You will be required to submit proof annually that you are still receiving disability benefits from the Social Security Administration.

If you are receiving retirement benefits from the Retirement Plan, you can obtain an award of T&P benefits only if you elected your retirement benefits prior to age 55, you were awarded Social Security disability benefits before you attained age 55, and you are still receiving such benefits.

Decisions by the Social Security Administration as to the onset date and causation of your disability are not binding on the Plan.

Employment Information

You may be totally and permanently disabled within the meaning of the Disability Plan if you are earning an income. The Disability Plan permits you to receive up to $30,000 per year in income and still qualify for T&P benefits.

IMPORTANT: The Disability Plan and the Social Security Administration have different standards for earned income. If your earned income exceeds the standards of the Social Security Administration, your disability benefits under the Social Security program may be terminated.

Mail the completed Application and required documentation to:

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Signature and Authorization

I certify that all information and documents provided on or with this Total and Permanent Disability Benefits Application are, to the best of my knowledge, true, correct, and complete. I also authorize the NFL Player Disability & Neurocognative Benefit Plan to use or disclose all individually identifiable health information submitted to the Plan on my behalf, or created in connection with my Application, to all individuals as needed for Plan purposes.

I understand that I may be required to undergo a comprehensive evaluation, and I certify that I will be able to attend such evaluation within 30 days from the date this Application is received by the Plan Office. I understand that failure to attend without 2 business days advance notice, and cooperate with such evaluation will result in my Application being denied.

Signature of Player _____ Date Completed _____

Player Information

Player's Name *(please print)* _____
Last First Middle Initial

Date of Birth _____ Social Security Number _____

Address *(number and street)* _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ E-mail _____

Medical, Hospital and Other Records

Have you included additional information in support of your Application for disability benefits?

❍ Yes ❍ No If yes, what is enclosed? _____

Are there other documents that you intend to include that you have not submitted with this Application?

❍ Yes ❍ No If yes, what will you be sending? _____

Note: Applications cannot be processed until all information is received. Please send all supporting information to the Plan Office as soon as possible, or notify the Plan Office if you decide not to send additional information.

Disabilities and Cause

(PART 1) Describe all of the conditions that you believe make you unable to work. Please state if any of these conditions resulted from service in the military of any country. You may attach additional sheets if necessary to identify the conditions which you would like the Plan to consider.

Condition 1: _____

Condition 2: _____

Condition 3: _____

Condition 4: _____

Condition 5: _____

— CONTINUED ON NEXT PAGE —

Player's Name *(please print)* _____ Initials _____

Disabilities and Cause (Continued)

(PART 2) Higher benefits are payable if the disability(ies) that renders you totally and permanently disabled arose while you were an Active Player, and caused you to be totally and permanently disabled "shortly after" the disability(ies) first arose. In such cases the amount of your benefit will depend on whether your disability(ies) results from NFL football. If you believe you may qualify for such higher benefits, please indicate below (a) when the disability(ies) arose, (b) when they caused you to be totally and permanently disabled, and (c) whether the disability(ies) resulted from NFL football or another cause (for example, auto accident). On (c), please list all injuries, accidents or illnesses that may have caused or contributed in any way to any of the conditions listed in section 4, Part 1. You may attach additional sheets or supporting documentation.

(a) _____

(b) _____

(c) _____

(PART 3) Describe the problems you are currently experiencing. _____

_____

_____

_____

_____

(PART 4) Please note that special rules apply when a condition relates to alcohol or substance abuse, or to psychiatric problems. In general, if such conditions are the cause of your inability to work, they will automatically be considered to not result from NFL football activities. Certain exceptions apply, as described in the Summary Plan Description. If you believe you qualify for one of these exceptions, please describe and enclose all supporting documentation.

_____

_____

_____

_____

Social Security

Are you currently receiving Social Security disability benefits? ❍ Yes ❍ No

If you checked **"Yes"** above, you must submit the following:

- a letter or other evidence from the Social Security Administration which states that the Social Security Administration determined you were unable to work; and
- a recent check stub or a letter from your local Social Security Administration office which states that you are still receiving Social Security benefits.

If you checked **"No"** above, have you applied? ❍ Yes ❍ No

If you are currently receiving Social Security disability insurance benefits, please disregard the Employment Information section.

— CONTINUED ON NEXT PAGE —

Player's Name *(please print)* _____ Initials _____

Employment Information

Are you currently employed? ❍ Yes ❍ No ❍ Never worked after playing NFL football

If you checked **"Yes,"** please complete the following and submit the requested documents:

Employer _____ Job Title _____ Start Date _____
Employer's Address _____
Supervisor's Name _____ Supervisor's Phone _____
Job Description _____ Salary *(before tax)* _____

Documents you must submit:

- Federal and state income tax returns for the last 3 years
- A description of your day-to-day job duties and resposibilities
- Current year salary information, such as a pay stub or letter from your employer

If you checked **"No,"** please complete the following:

Your Last Employer _____ Job Title _____ Start & End Dates _____
Employer's Address _____
Supervisor's Name _____ Supervisor's Phone _____
Job Description _____
Reason for leaving _____

— CONTINUED ON NEXT PAGE —

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Disability Benefit Player Consent Form

Signature and Authorization

You are applying for disability benefits under the NFL Player Disability & Neurocognitive Benefit Plan ("Plan"). This form contains important information. Please read the form, sign it, and return it with your application for disability benefits. This form is a required part of the application, and must be completed before your application will be processed.

I, _____ *(print name)*, have read and understood the information in this Disability Benefit Player Consent Form.

Signature of Player _____ Date Completed _____

In submitting my application for disability benefits, I understand that:

1. I may be required to attend a physical examination with one or more physicians or other health professionals, and that failure to attend may cause my application to be denied.

2. There will be no doctor-patient relationship between me and the physicians or other health professionals who examine me.

3. The physicians or other health professionals who examine me will provide reports on my condition to the Plan, which I may obtain by written request to the Plan Office.

4. The physicians or other health professionals who examine me will not provide a copy of the medical reports to me directly.

5. Neither I nor my representatives (attorneys, treating physicians, etc.) are allowed to contact the physicians or other health professionals arranged by the Plan, such as to discuss their examination of me or to request copies of reports.

6. The physicians or other health professionals who examine me are required to comply with ethical or legal obligations, for example if they determine that I am a danger to myself or to others.

7. By signing this form, I consent to the above points and will comply with the Plan's procedures in connection with my claim for disability benefits.

8. The examination will not be videotaped or otherwise recorded.